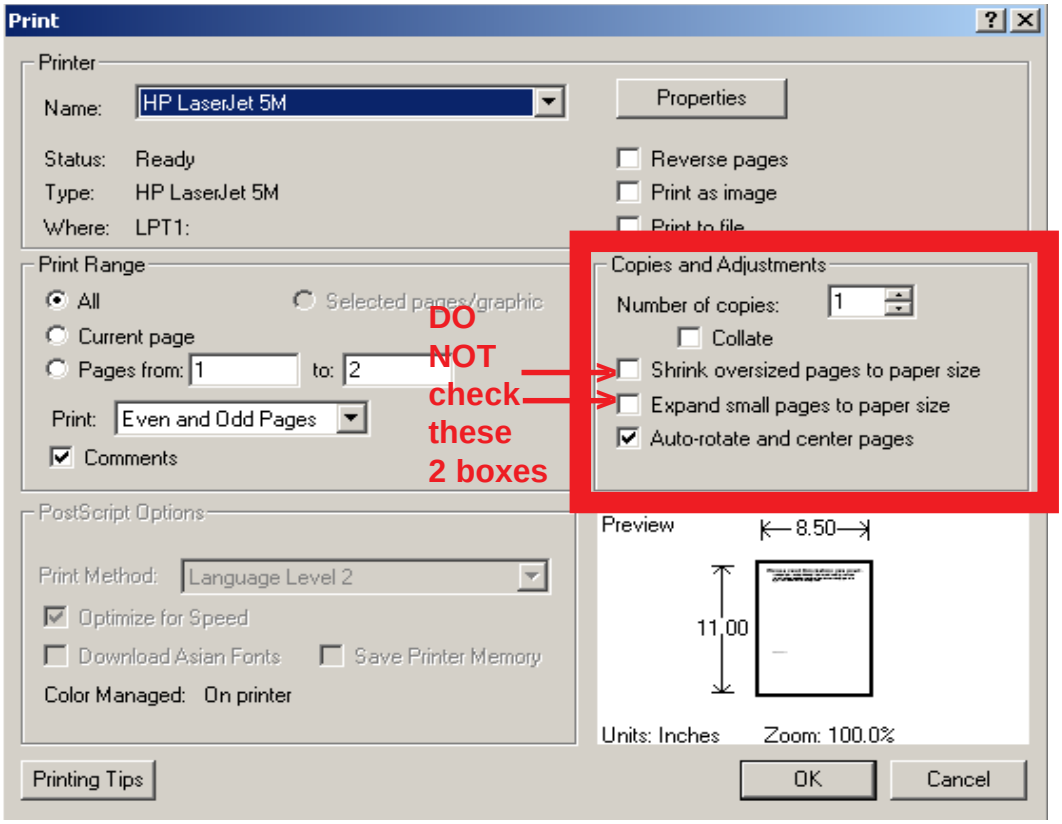
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Podiatric Medicine and Surgery License Application Packet

1. 665-005 Contents List/SSN Information/Deposit Slip ..... 1 page
2. 665-001 Application for License to Practice Podiatric Medicine and Surgery ..... 4 pages
3. 665-007 Application Instructions for Licensure—Podiatric Physician and Surgeon ..... 4 pages
4. 665-008 Postgraduate Training Investigative Letter ..... 1 page
5. 665-009 Hospital Investigative Letter ..... 1 page
6. 665-010 State Licensure Investigative Letter ..... 1 page
7. 665-012 Podiatric Medical Board—Limited License Postgraduate Training Verification ..... 1 page
8. 665-011 Podiatric Medical Board—Request for Physician Disciplinary Profile/PMLexis Score Report .... 1 page

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Podiatric Physician and Surgeon

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 665-005 (REV 5/2004)

1F 0252010000 00357

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Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE NUMBER	DATE

Application For License To Practice Podiatric Medicine And Surgery

LICENSE #

Application for (check one):

- ☐ **PMLexis Examination**
- ☐ **National Board/PMLexis Endorsement**
- ☐ **Temporary Licensure**
- ☐ **Limited Licensure**

Please Type or Print Clearly—Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Supporting documents should be filed with the Health Professions Quality Assurance Division at least sixty (60) days before license is needed. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health.

All applications must be accompanied by applicable fees (fees are nonrefundable). For applicable fee, please see instructions. Mail remittance payable to Department of Health, Revenue Section.

NOTE: The mailing address you provide will be listed on your license and all correspondence from the Department will be sent to this address until you notify us of a change.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS

CITY	STATE	ZIP	COUNTY

BUSINESS TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)
( )	( )	— —

GENDER	BIRTHDATE (MO/DAY/YR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male	/ /	

HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR

MEDICAL SPECIALTY

PODIATRIC SCHOOL	YEAR GRADUATED

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

2. Education and Training

Provide a chronological listing of your educational preparation and postgraduate training. Attach additional 8 1/2 x 11 sheets if necessary.

SCHOOLS ATTENDED	NUMBER OF YEARS ATTENDED	DATES OF ATTENDANCE FROM (MO/YR)	DATES OF ATTENDANCE TO (MO/YR)
PODIATRIC MEDICAL EDUCATION			
RESIDENCY PROGRAM (IF APPLICABLE)			

3. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ..... ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ..... ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ..... ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ..... ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ..... ☐ ☐

   b. a charge of a sex offense? ..... ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ..... ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ..... ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ..... ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ..... ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ..... ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ..... ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ..... ☐ ☐

4. Professional Experience

In chronological order list all professional experience received since graduation from your podiatric medical school to the present. Exclude activities listed under other sections. (Attach additional 8 1/2 x 11 sheets if necessary.)

NAME OF EXPERIENCE OR PRACTICE AND LOCATION	ATTENDANCE	
	FROM (mo/yr)	FROM (mo/yr)

5. Hospital Privileges

List hospitals and locations where privileges have been granted within the past five (5) years.
(Attach additional 8 1/2 x 11 sheets if necessary.)

NAME OF HOSPITAL AND LOCATION	DATES	
	FROM (mo/yr)	TO (mo/yr)

6. Previous Licensure

List all licenses granted with type, date, grantor, and if license is active or inactive. (Attach additional 8 1/2 x 11 sheets if necessary.)

STATE OR OTHER	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YEAR	NUMBER		EXAMINATION	OTHER	
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No
				☐ Perm ☐ Temp			☐ Yes ☐ No

7. AIDS Education and Training Attestation

I certify I have completed the minimum of 7 hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

8. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Application Instructions for Licensure Podiatric Physician and Surgeon

To qualify for licensure as an Podiatric Physician and Surgeon in the state of Washington, one must have received a diploma or certificate of graduation from a legally incorporated, regularly established school of podiatry approved by the Podiatric Medical Board.

An applicant for a license to practice podiatric medicine and surgery must furnish evidence satisfactory to the board that the applicant has completed one year of postgraduate podiatric medical training in a program approved by the board, provided that applicants graduating before July 1, 1993, shall be exempt from the postgraduate training requirement. Programs approved by the American Podiatric Medical Association Council on Podiatric Medical Education which are listed in the 1992-1993 directory of Approved Residencies in Podiatric Medicine, or programs approved by the Council on Podiatric Medical Education at the time the post graduate training is obtained are acceptable programs.

Washington State Podiatric Medical Law requires an examination of all applicants for licensure. All applicants must pass Part I and Part II of the National Board Examination prepared by the National Board of Podiatric Examiners. Certified scores for the National Board Examination may be obtained from: **National Board of Podiatric Medical Examiners, P.O. Box 6516, Princeton, New Jersey 08541-6516, Telephone (609) 921-9200.**

In addition, successful completion of a written examination that is approved by Washington State is required. The Podiatric Medical Board currently accepts the PMLexis Part III examination. Scores from the PMLexis taken in another state are acceptable if taken on or after June, 1988.

Please indicate at the top of the application whether you are applying by examination, endorsement or limited licensure. If the applicant has had a name change or documents were issued in a name other than the one currently being used, please indicate those names when submitting the application. When the required documentation has been received, applications will be reviewed.

Application For Examination

Applicants must submit:

1. Completed application form with signatures.
2. Signed affidavit indicating completion of seven hours of AIDS education.
3. Official transcript sent directly to the board from the college where the podiatric degree was obtained.
4. National Board Examination scores, Parts I and II, certified and sent directly to the board from the National Board of Podiatric Medical Examiners, PO Box 6516, Princeton, NJ 08541-6516 (609) 720-6698. Contact National Boards for score verification fees.
5. Verification letters sent directly to the board from all states in which you have ever obtained a podiatric medical license. Some states require a fee for processing verification letters. Please check with each state to determine this fee.
6. Verification of all accredited postgraduate podiatric medical training. Forms must be completed by the office of the program director of the training program and returned directly to this office. Verification will be considered incomplete without the beginning and ending dates of the training.
7. Verification letters sent directly to the board from all hospitals where the applicant has had hospital privileges in the last five (5) years.

8. Verification letters sent directly to the board from the Federation of Podiatric Medical Boards' disciplinary data bank. **Disciplinary reports are $50.00 per report.** The report may be requested from the Federation at 6551 Malta Drive, Boynton Beach, FL 33437, (561) 752-3735.
9. Application fee $825.00. Make checks payable to the Department of Health.

Beginning with December 2000 exam, the PMLexis Part III will be conducted by Computer Based Testing (CBT) and will be given at numerous sites across the country. You do not need to take the exam in the state where you are applying for licensure.

In order for the candidate to meet the test administrator's deadline, the licensing application and fee need to be received by the Board staff **30 days before** the testing deadline (see below). **You will also need to complete the PMLexis Part 3 application and send the fee of $900 to the Chauncey Group (test administrator).** Test administration applications and instructions may be received from the National Board of Podiatric Medical Examiners, 664 Rosedale Road, Princeton, NJ 08540, (877) 302-8952. Verification of eligibility to sit the PMLexis (Part 3) examination will be sent to the Chauncey Group from the Board.

If you have a disability that may require some accommodation in taking the PMLexis Part III examination, please request the "Request for Accommodation Form" from the PMLexis office.

Examination and Deadline dates for the PMLexis Part III application are below. Only one day is necessary to complete the exam. You will be able to choose which day, subject to availability at the test site selected.

Examination Date	Chauncey Group Deadline Date
First Tuesday and Wednesday of **December**	60 days prior to testing
Second Tuesday and Wednesday of **June**	60 days prior to testing

Scores will be sent to the board approximately 2 weeks after the exam. Please allow additional time for processing the license.

All supporting documents and PMLexis scores must be received before the application will be reviewed for licensure.

Application for Endorsement

Applicants must submit:

1. Completed application form with signatures.
2. Signed affidavit indicating completion of seven hours of aids education.
3. Official transcripts sent directly to the board from the college where the podiatric degree was obtained.
4. National Board Examination Scores, Parts I and II, certified and sent directly to the board from the National Board of Podiatric Medical Examiners, PO Box 6516, Princeton, NJ 08541-6516. (609) 720-6698. Contact National Boards for score verification fees.
5. PMLexis Part III examination scores certified and sent directly to the board from the Federation of Podiatric Medical Boards, 6551 Malta Drive, Boynton Beach, FL 33437, (561) 752-3735. **PMLexis Score Reports are $45.00 per report.**
6. Verification letters sent directly to the board from all states in which you have ever obtained a podiatric medical license. (Some states require a fee for processing verification letters. Please check with each state to determine this fee.)
7. Verification of all accredited postgraduate podiatric medical training. Forms must be completed by the program director of the training program and returned directly to this office. Copies of evaluations, or a summary of the applicant's performance, must accompany the completed form. Verifications will be considered incomplete without an evaluation, and must include the beginning and ending dates of the training.

8. Verification letters sent directly to the board from all hospitals where the applicant has had hospital privileges in the last five years.
9. Verification sent directly to the board from the Federation of Podiatric Medical Board's, 6551 Malta Drive, Boynton Beach, FL 33437, (561) 752-3735, disciplinary data bank. **Disciplinary Reports are $50.00 per report.**
10. Application fee of $825.00 made payable to the Washington State Department of Health.

Limited Licensure

Applicants must submit:

1. Completed application form with signatures.
2. Signed affidavit indicating completion of seven hours of AIDS education.
3. Official transcripts sent directly to the board from the college where podiatric degree was obtained.
4. Verification letters sent directly to the board from all states in which you have ever obtained a podiatric medical license, if applicable. Some states require a fee for processing verification letters. Please check with each state to determine this fee.
5. Limited License Verification Postgraduate Training letter from the accredited podiatric postgraduate medical training program that the applicant is entering in Washington State.
6. Verification letters from all accredited podiatric postgraduate training programs that the applicant has attended, if applicable. Verification must include beginning and ending dates of training.
7. Verification letters sent directly to the board from all hospitals where the applicant has had hospital privileges in the last five (5) years.
8. Verification sent directly to the board from the Federation of Podiatric Medical Boards, 6551 Malta Drive, Boynton Beach, FL 33437, (561) 752-3735, disciplinary data bank. **Disciplinary Reports are $50.00 per report.** Recent graduates do not need to submit this report.
9. Application fee of $400.00 made payable to the Washington State Department of Health.
10. Limited licenses are issued for a one year period beginning with the date of entry into the training program. Limited licenses are renewable annually.

Temporary Permits

A temporary permit to practice Podiatric Medicine and Surgery may be issued to an individual in another state that has substantially equivalent licensing standards to those in Washington. This license is only for applicants who are applying for full licensure. Temporary permits shall expire after 60 days.

Note: A temporary permit shall be issued only once to each applicant. An applicant who does not complete the application process shall not receive a subsequent temporary permit.

1. Documentation from the reciprocal state that the licensing standards used for issuing the license are substantially equivalent to the current Washington licensing standards.
2. A completed application form, application fee of $825, and temporary permit fee of $50.
3. Verification of all state licenses, whether active or inactive, indicating that the applicant is not subject to charges or disciplinary action for unprofessional conduct or impairment.
4. Verification from the Federation of State Podiatric Medical Board's disciplinary action data bank that the applicant has not been disciplined by a state board or federal agency. Disciplinary Reports are $50.00 per report and may be obtained from the Federation, 6551 Malta Drive, Boynton Beach, FL 33437, (561) 752-3735.

The temporary permit shall be issued for 60 days at which time it will become invalid. The temporary permit shall be returned to the Department of Health upon expiration or receipt of a full license. A temporary permit shall be issued only once to each applicant.

Please note: Because verification from the reciprocal state that standards for licensure are substantially equivalent to Washington standards is required, the temporary license process may not be as expeditious as obtaining full licensure.

Application Fees are Non-Refundable.

Send application and fee to:

Podiatric Medical Board
PO Box 1099
Olympia, Washington 98507-1099

(360) 236-4943

Send all supporting documents to:

Licensing Representative
Podiatric Medical Board
PO Box 47869
Olympia, Washington 98504-7869

(360) 236-4943

Renewal Information and Assistance or Application Packets:

Customer Service Center

(360) 236-4700

For the Hearing Impaired, please call (360) 664-0064.

Washington State Department of Health
Podiatric Medical Board
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

Postgraduate Training Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice Podiatric medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my postgraduate training and return it directly to:

Department of Health
Podiatric Medical Board
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Podiatric Medical Board.

SIGNATURE OF APPLICANT _____ DATE _____

1. Is the applicant currently or has the applicant ever been engaged in postgraduate training in your program?
   ☐ Yes ☐ No Beginning Date _____ Ending Date _____
2. Briefly evaluate the applicant's competence and conduct during the program _____
   _____
   _____
3. Has the program ever had cause to restrict, suspend or terminate, or ask for a voluntary resignation of the applicant's participation in the program? ☐ Yes ☐ No If yes, explain and include performance evaluations.
   _____
4. Is there any information in your files that could call into question the applicant's ability to safely practice Podiatric medicine and surgery? ☐ Yes ☐ No If yes, explain _____
   _____

Name _____

Title _____

Facility _____

Address _____

_____

Telephone Number _____

Authorized Signature _____

Date _____

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Washington State Department of Health
Podiatric Medical Board
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

Hospital Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice Podiatric medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my hospital privileges and return it directly to:

Department of Health
Podiatric Medical Board
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Podiatric Medical Board.

SIGNATURE OF APPLICANT _____ DATE _____

1. Does the applicant, currently or has the applicant ever had any practice privileges at your hospital? ☐ Yes ☐ No

   Beginning Date _____ Ending Date _____

2. Has the applicant's privileges ever been restricted, suspended or revoked by the medical staff office or administration? ☐ Yes ☐ No

   If yes, explain _____

3. Has the applicant ever been asked to resign or surrender any privileges voluntarily in lieu of action being taken? ☐ Yes ☐ No

   If yes, explain _____

4. Is there any information in your files that could call into question the applicant's ability to safely practice podiatric medicine and surgery? ☐ Yes ☐ No

   If yes, explain _____

Name _____

Title _____

Facility _____

Address _____

_____

Telephone Number _____

Authorized Signature _____

Date _____

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Washington State Department of Health
Podiatric Medical Board
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4943

State Licensure Investigative Letter

NAME OF APPLICANT (Please Print) _____ BIRTHDATE (MONTH/DAY/YEAR) _____

I have applied for a license to practice Podiatric medicine and surgery in the state of Washington. Before my request for a license can be reviewed, a background investigation must be completed. Please complete the following questionnaire relative to my state licensure and return it directly to:

Department of Health
Podiatric Medical Board
PO Box 47869
Olympia, Washington 98504-7869
(360) 236-4943

Please reply as soon as possible to avoid delays in the licensing process.

I hereby authorize you to release the following information to the Washington State Podiatric Medical Board.

SIGNATURE OF APPLICANT _____ DATE _____

To assist the Washington State Board in evaluating the above physician's application, we would appreciate receiving the following information.

License Number _____ Date license was issued _____

Status of License: ☐ Active ☐ Military ☐ Other _____
☐ Inactive ☐ Expired

Has the applicant's license ever been suspended or revoked? ☐ Yes ☐ No

Has any other disciplinary or corrective active been taken? ☐ Yes ☐ No

Has the licensee surrendered the license in lieu of disciplinary action? ☐ Yes ☐ No

If you have answered Yes to any of the questions above, attach supporting documentation pertaining to disciplinary orders or any other actions.

State Seal

State Board _____

Address _____

_____

Telephone Number _____

Authorized Signature _____

Date _____

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
P.O. Box 47869 • Olympia, Washington 98504-7869

Podiatric Medical Board

Limited License Postgraduate Training Verification

This is to certify that _____ has been accepted in
NAME OF PODIATRIC PHYSICIAN

a postgraduate training program in _____ at
SERVICE

_____ for the period beginning
INSTITUTION

_____. The individual responsible for this resident's patient care
START DATE

activities will be _____ , _____ .
PRINT NAME DIRECTOR OF PROGRAM SIGNATURE

* A resident Podiatric Physician means an individual who has graduated from an approved school of podiatric medicine, and is serving a period of postgraduate clinical training sponsored by a college or university in this state or by a hospital accredited in this state whose program is approved by the American Podiatric Medical Association Council on Podiatric Medical Education. The term shall include individuals designated as intern, resident, Podiatric fellow.

Return Completed Form to:

Podiatric Medical Board
PO Box 47869
Olympia, WA 98504-7869

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

P.O. Box 47869 • Olympia, Washington 98504-7869

Podiatric Medical Board

Request For Physician Disciplinary Profile/PMLexis Score Report

This form is to be completed by the Podiatric physician and surgeon and mailed directly to the address below along with a $50.00 fee for Disciplinary Reports plus $45.00 fee for PMLexis Part III Score Reports **(exam candidates do not need to request scores):**

Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach, FL 33437
(561) 752-3735

Beginning March 1, 2004, the Federation of Podiatric Medical Boards will accept orders for PMLexis/Part III Score and Disciplinary reports via an "Order Reports" button on its web site (www.fpmb.org). After filling out an on-line form, visitors will have the option to immediately pay for requests with their MasterCard or Visa credit card.

Please Print or Type

Full Name: _____
FIRST MIDDLE LAST (Maiden-optional)

Address: _____
STREET CITY STATE ZIP

Date of Birth: _____ Place of Birth: _____

Phone Number: _____ Email Address: _____

Podiatric Medical School: _____

Date of Graduation: _____ Social Security Number: _____

PMLexis Information: State taken: _____ Date taken: _____

_____ _____
APPLICANT SIGNATURE DATE

Federation of Podiatric Medical Boards—Please return information to the following State Agency:

Department of Health
Podiatric Medical Board
PO Box 47869
Olympia, WA 98504-7869
(360) 236-4943

Federation Stamp